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Article (Accepted Version)

Braye, Suzy, Orr, David and Preston-Shoot, Michael (2012) The governance of adult safeguarding: findings from research. *Journal of Adult Protection*, 14 (2). pp. 55-72. ISSN 1466-8203

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The Governance of Adult Safeguarding: Findings from Research

Suzy Braye, David Orr and Michael Preston-Shoot

Abstract

Purpose - This article reports the findings from research into the governance of adult safeguarding policy and practice in England, with particular focus on interagency partnership arrangements expressed through Safeguarding Adults Boards.

Design - The study comprised a systematic search and thematic analysis of English-language literature on adult safeguarding governance, a survey of Safeguarding Adults Board documentation, and key informant interviews and workshops with professionals involved in adult protection.

Findings - The effectiveness of adult safeguarding governance arrangements has not been subject to prior formal evaluation and thus the literature provided little research-led evidence of good practice. The survey and workshops, however, revealed a rich and complex pattern of arrangements spanning a number of dimensions – the goals and purpose of interagency working, the structures of boards, their membership, chairing and rules of engagement, their functions, and their accountabilities.

Research limitations/implications - The research focus was England, and thus does not incorporate learning from other jurisdictions. Whilst the research scrutinised the extent to which Boards practise empowerment, service users and carers were not directly involved in the fieldwork aspects of this study. In view of the absence of outcomes evidence identified, there remains a need to investigate the impacts of different forms of governance.

Practical implications - Drawing on this research and on governance frameworks in the context of related interagency fields, the article identifies standards to benchmark the approach to governance taken by Safeguarding Adult Boards.

Value - The benchmarking framework will enable Safeguarding Adults Boards to audit, evaluate and further develop a range of robust governance arrangements.

Key Words - Governance, Safeguarding Adults Boards, adult protection

Paper type - Research paper

Introduction

Safeguarding adults is a multi-agency responsibility that is increasingly subject to political and public scrutiny. Policy guidance (DH 2000) encouraged local authorities to establish partnership bodies, now known as Safeguarding Adults Boards, with membership that includes statutory and independent agencies, and community organisations and groups, including service users and carers. Directors of Adult Social Services carry specified lead responsibility and authority. Under the guidance, Boards should “determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress” (p15).

The Care Quality Commission (formerly the Commission for Social Care Inspection) has found considerable diversity of adult safeguarding practice, despite the existence of national standards (ADSS, 2005a) throwing into doubt the effectiveness of local arrangements. The Commission (CSCI, 2008) was particularly concerned about inadequate participation from partner agencies, disconnection from the challenges of practice, limited resources and under-developed mechanisms for effective scrutiny and governance. A study of serious case reviews (Manthorpe and Martineau, 2009) identified concerns about the consistency of arrangements for reviewing serious incidents and about the extent to which findings impact on subsequent interagency practice. Penhale *et al* (2007) noted that, despite the perceived benefits of partnership working discernible in the views of those involved, its implementation had been highly variable. Another review (Mowlam *et al.*, 2008) concluded that knowledge and understanding of roles and responsibilities within professional networks on safeguarding required further development. Subsequent government strategy has recognised that an effective safeguarding system requires clarity of interagency roles and responsibilities, and coherent leadership, vision and strategic direction (DH, 2010a). The Law Commission’s proposals for the reform of adult social care law (2011) pay specific attention to the legal rules underpinning this work, including a proposal to place Boards on a statutory footing.

Research methods

The research reported here, commissioned by the Department of Healthⁱ and completed in 2010 (Braye *et al*, 2011a), sought to identify best practice in the governance of safeguarding adults, focusing specifically on the interagency arrangements under the auspices of Safeguarding Adults Boards. Key areas for scrutiny were Boards’ strategic goals, vision and purpose, their structures and membership, along with their functions and accountabilities.

Five data sources were used. First, a search of the literature, following systematic review principles, identified 3,162ⁱⁱ potentially relevant references. The abstracts of these were screened against date limits (publication post-2000ⁱⁱⁱ) and content relevance criteria, resulting in a final selection of 44 papers. Data relevant to the research focus were then extracted and subjected to thematic analysis.

Second, professionals involved in adult safeguarding attended a series of workshops. Invitations were sent to all authorities through regional safeguarding networks, and participants included Board chairs, directors of adult services, safeguarding leads and others with specialist safeguarding roles, including participants from the NHS and the police. Four initial workshops, involving 31 participants, explored views about the role and functions of Safeguarding Adults Boards. Three later workshops attended by 44 participants (including a number of repeat attenders) provided expert review and comment on the research findings.

Third, documentation relating to 47 Safeguarding Adults Boards was reviewed to capture information about strategies, structures, membership, functions, and accountability arrangements. The documents (a total of 203) were submitted by authorities, or were secured through scrutiny of local authorities' (and in some cases safeguarding partnerships') websites, and Care Quality Commission reports. The sample was constructed initially from authorities responding to an invitation to submit documentation. These were then matched to the overall profile of CQC gradings on annual performance monitoring of Outcome 7 of the Outcomes and Performance Framework - Maintaining Personal Dignity and Respect (CQC, 2009), and additional sampling took place to ensure a proportionate representation of authorities in the "Performing Well" and "Performing Adequately" categories. All authorities graded as "Performing Excellently" were included in the sample in order to identify any particular features associated with excellent performance. In addition, thirteen CQC adult social care inspection reports dating from 2008 and 2009 were reviewed to extract findings on safeguarding and identify markers associated with higher grades.

CQC 2009 scores on outcome 7: N=153 Total sampled = 47 (31%)

| | All local authorities | | Our sample | |
|--------------------|-----------------------|-------------|------------|-------------|
| | | | | |
| Excellently | 12 | 8% | 12 | 25% |
| Well | 90 | 59% | 21 | 45% |
| Adequately | 45 | 29% | 13 | 28% |
| Poorly | 2 | 1% | 0 | 0% |
| Not rated | 4 | 3% | 1 | 2% |
| | 153 | 100% | 47 | 100% |

Fourth, 5 expert informants were interviewed, selected for their engagement with adult safeguarding governance issues in roles that gave them a national overview perspective. Their views and experiences of governance matters were sought through open ended, topic driven questions.

Finally, data from regional and national safeguarding work programmes, taking place at the same time as the research, were considered. These included:

- A regional Joint Improvement Partnership (JIP) programme relating to governance;

- Data from two research projects in one region through a partnership between the regional JIP, the regional government office and the Association of Directors of Adult Social Services (ADASS);
- Presentations from a regional conference;
- Reports from a national work-stream led by the Improvement and Development Agency for Local Government (IDeA).

Ethical approval was granted by the National Social Care Research Ethics Committee^{iv}.

Findings

Five key features of Safeguarding Adults Boards have a key role in fulfilling governance arrangements in relation to adult safeguarding: the strategic goals and purpose of boards; their structures; their membership, chairing and rules of engagement; the functions they perform; and the accountabilities they engage. These dimensions, however, are more remarkable for the diversity than for the consistency of their features, and there is little robust evidence that one model of strategy, structure, membership, function and accountability is more effective in ensuring good governance than any other. The features and their governance role are explored in turn below.

Strategic goals and purpose

A push for strong strategic leadership from boards, and a separation of this strategic role from operational matters, were noticeable trends. Participants considered this to be in response to a perceived over-emphasis on operational matters at the expense of strategic direction in interagency partnership terms and a wish to provide stronger leadership.

Central to the question of determining core strategic purpose is the way Boards define the territory in which they operate. Thus definitions – of the nature and scope of safeguarding and its target population – are core considerations in identifying the nature of Boards' business and overall mission. Literature that explicitly addresses the question of definition is sparse, lending support to the observation (Manthorpe et al, 2005) that researchers have not explored it to any great extent; in the context of broad definitions of safeguarding (Manthorpe et al 2008) an array of different types of maltreatment are included (Filinson et al 2010).

In practice, whilst much Board activity was concerned with setting strategic frameworks for protecting individuals where abuse or neglect is observed or suspected, Boards also engaged in activities far wider than those implied by the definitions in *No Secrets* (DH 2000). These definitions focus primarily upon responses to vulnerable adults, defined as those eligible for community care services, whereas Boards' remit extended well beyond these populations to encompass work with wider communities and groups, including work in the context of domestic abuse, forced marriage, hate crime and community safety. This wider work tended not to

be proceduralised but was often conducted through awareness-raising with other partnerships and/or directly with communities, and its scope was potentially limitless. Curiously, despite the breadth of focus, some areas of risk were often excluded from the formalised scope of safeguarding – notably suicide and self neglect – although safeguarding work in practice did take place with people who posed risks to themselves, and a number of serious case reviews have explored how interagency networks had responded in cases of self neglect. Equally, researchers (McCreadie et al., 2008) have voiced concern that, whilst eligibility thresholds (DH, 2002; 2010b) clearly place people being abused or neglected in categories of critical or substantial risk, the exclusion from eligibility of people assessed as presenting with lower levels of risk may result in cases of abuse and neglect being missed.

Drawing together data from the literature and from board documentation, it is possible to discern two clear axes of activity – the preventive/reactive spectrum and the individual/community spectrum. These axes in effect define the parameters of safeguarding, as it is interpreted within particular localities, and are set out in Figure One. Boards generally expressed greater confidence in their core purpose of preventing and responding to abuse and neglect of individuals than in their engagement with the broader community safety agenda, particularly when financial pressures evoke concern about how to maintain and demonstrate effectiveness.

FIGURE ONE ABOUT HERE

Further shifts in definitions of the scope of safeguarding, and therefore the purpose of Boards, have arisen in the context of personalisation, where the safeguarding focus shifts from making protective interventions determined by professionals to supporting people to engage in self-protection in the context of autonomous decisions. Boards were working to embrace personalisation and promote more empowering ways of working with individuals and communities. They also recognised that self directed support may open up new risks and required new ways of working. There was consensus that the language of safeguarding should move away from an emphasis on vulnerability to a perspective that recognises individual strengths and capabilities, empowers people's own decision-making and supports their ability to protect themselves.

An often quoted phrase in documentation and in discussion was *"safeguarding is everybody's business"*. This can, however, contain an ambiguity that impacts upon the strategic purpose of boards. One interpretation is that *"we must all do safeguarding"* - everyone must engage with endeavours to protect vulnerable individuals from harm; this would lead Boards to reach out to a wide range of stakeholders to ensure that appropriate ways of preventing and responding to abuse are well understood and concerns are reported into the safeguarding system. The other interpretation is that *"everything we all do is safeguarding"* – the activities of a wide range of networks and agencies contribute to everyone's safety; this would lead Boards to see the scope of their work very broadly, and to attempt to hold within their remit all the work done by any element of public services that can help minimise risk. This duality of interpretation goes to the heart of debates about the

strategic purpose of Boards, and the issue of definition is captured by the Law Commission (2011) *“Whilst safeguarding relates to the prevention of abuse and has a broad focus that extends to all aspects of a person’s general welfare, adult protection refers to investigation and intervention where it is suspected that abuse may have occurred”* (p110).

Despite such variations in the focus of their strategic goals and purpose, Boards commonly set out a range of key principles (Figure Two) that underpinned their work.

FIGURE TWO ABOUT HERE

Capacity was recognised as a key factor in determining respect for autonomy of decision-making, but so too was the concept of a duty of care that might require intervention to be pursued. The notion of dignity was sometimes used as a balancing factor, driving work that sought to empower people to envisage the possibility of choosing abuse free options for themselves. The rights of carers, care providers and staff were also recognised, along with a duty of care to people who present risk of harm to others. No easy solutions exist when having to balance competing rights (Filinson, 2008; Manthorpe et al., 2008) even when practice aspires to empowerment.

Structure

Boards experienced tension between creating a tightly defined strategic group of senior officers who could commit their agencies to decisions, and including a wide range of stakeholders in the Board. This resulted in a wide diversity in the number of Board members, with anything between 10 and 47. The broadening scope of safeguarding had brought increased membership beyond figures quoted by Penhale et al (2007), as Boards seek to engage with community groups, with other locality partnerships, and with the diversified structures within the NHS. The wider the definition and scope of safeguarding, the larger the number of perceived stakeholders.

The push to strengthen strategic leadership had led Boards to create layered structures, each tier holding a different level of responsibility, from strategic to operational. In some cases the Board restricted its membership but created an operational group with responsibility for implementation. In other cases the Board remained wide and inclusive but an executive group, with responsibility for leadership and strategic decision-making, sat above it. Thus there was a degree of horizontal differentiation. No research was found that had evaluated these different approaches.

Whatever the structure adopted for differentiating strategic and operational roles, it was common for sub-groups to coordinate different strands of activities, thus creating vertical differentiation between functions. Each Board clustered its activities into sub-groups in slightly different ways, but typically ran several groups covering such elements as workforce development; quality assurance; communications;

policy, procedures and practice development, and serious case reviews. Boards in larger authorities sometimes convened locality-based groups, and some Boards convened groups to facilitate service user and carer participation, or to provide opportunities for practitioners and care providers to meet. Increasingly responsibilities were merging into task and finish groups to reduce the burden of meetings falling on a small number of professionals. All groups were commonly constituted with a degree of formality, with terms of reference and membership requirements, formal authority and accountabilities. The literature has reported, rather than evaluated, different types of sub-groups (Dodd and Lamb, 2004; Giordano and Badmington, 2007).

The more differentiated the structure, the more important became the coordinating mechanisms – vertical channels of communication between hierarchical layers, and horizontal communication channels between functionally diverse sub-groups – in order to maintain a coherent and coordinated structure. Figure Three captures this challenge of coordination, rarely spelled out in Board documentation, but often in practice the responsibility of a business manager or safeguarding co-ordinator.

FIGURE THREE ABOUT HERE

Strategic links with other locality partnerships emerged as an essential element of a Board's location. These links performed different functions in relation to the Board's strategic alignment and accountabilities. Figure Four captures these functions. Noticeable by their absence were the lack of formal links with NHS safeguarding boards, a connection not necessarily addressed through NHS membership of Safeguarding Adults Boards. Despite the links with local partnerships, both the literature (Manthorpe et al., 2008) and workshop participants reported that it was sometimes difficult to get safeguarding on their agenda; developing protocols can, however, prove beneficial (McKeough, 2009).

FIGURE FOUR ABOUT HERE

Some Boards had created strong links outside their own area to discuss joint approaches, to agree cross boundary protocols, to adopt joint procedures and approaches to practice, and to run shared sub-groups and training. Independent chairs had also developed links with each other. Regional JIP work programmes on safeguarding were experienced as helpful and supportive in developing and sharing practice. However, none of these initiatives had been fully evaluated.

Board Membership and Network Patterns

Interagency collaboration is central to the question of Board membership and to expectations about what members bring to the table. As reported in the literature, despite strong commitment to the assumed benefits of partnership in terms of coordination, consistency and positive outcomes (Perkins et al 2007), working together could be disrupted by a number of factors, including inadequate understanding of legal rules (Perkins et al., 2007; Pinkney et al., 2008) and a clash of

cultures, attitudes, priorities and thresholds (Rushton et al., 2000; Harbottle, 2007; Filinson, 2008; McCreadie et al., 2008). High-level strategic partnership did not always result in local collaboration (Manthorpe et al 2008; Ramsay 2009) and Boards were not always sufficiently engaged with NHS structures (Clarke 2002). Not every agency or professional group saw safeguarding as part of their remit (Draper et al 2009) and, whilst the broadening of the safeguarding agenda introduced new partners, such as trading standards, less familiar with such collaborative working (Perkins et al., 2007), some groups such as voluntary and private sector providers did not routinely participate (Penhale et al 2007) despite their strategic importance to fulfilment of safeguarding goals (Quigley 2001). GPs equally remained less well engaged (CSCI, 2008a; Cambridge and Parkes 2006b: 831; Draper et al., 2009; Harbottle 2007; McCreadie et al., 2008; Penhale et al., 2007; Pinkney et al., 2008). Current guidance (DH, 2000) was seen as permissive and insufficiently robust to guarantee commitment amongst agencies to cooperate and commit resources (Filinson, 2008; Pinkney et al., 2008) prompting calls for a statutory duty to cooperate (Perkins et al., 2007; Reid et al., 2009). Nonetheless, the literature also contained a few examples of building multi-agency collaboration through a whole systems event (Doonan, 2002) and creation of a provider forum (Giordano and Street, 2009).

The literature provides some information on membership. An early study of *No Secrets* implementation (Mathew et al., 2002) found representation from social services, health and the police on all Adult Protection Committees. A later survey (Perkins et al., 2007) provides an overview of 133 Boards across England and Wales, demonstrating that the most common members are local authorities (100%), NHS and Health Trusts (96.7%) and the Police (93.5%). Less consistently represented are PCTs (69.9%) and charities/voluntary organisations (65%); the Probation service, prisons, mental health trusts, housing departments, carers and service users, independent sector organisations and CPS are represented on around a third of Boards, whilst a wide range of diverse groups and organisations are involved in less than a quarter. Others (Sumner, 2004) note similar variation, and Reid et al (2009) are critical of the absence of a standard membership, or of the under-representation of groups and professionals managing service users' finances (Wilson et al., 2003).

This picture was repeated in the present survey of Boards; membership varied widely in terms both of the number of agencies represented and the number of individuals attending from each agency. Health, police and adult social care normally (in 43 of the 47 Boards reviewed) formed a core, with more variable membership from a wider range of members holding less clearly defined roles and expectations, and some, such as CPS and CQC, in an advisory capacity. Membership might be of sub-groups or forums rather than the Board itself. Figure Five shows the span of membership on a composite basis (no one Board had membership from all groups listed).

FIGURE FIVE ABOUT HERE

Lack of co-terminosity presented challenges to consistency – a single organisation with a wide geographical span could be required to work in very different ways by several different Boards. There were challenges too in securing participants who might represent their sector, particularly in relation to voluntary and independent sector providers, and then in clarifying their role. Gaps were filled sometimes through open public consultation meetings and events that engaged people in the work of the Board, even if they did not have membership.

There was a strong push for seniority of membership in the Board. Important attributes were ability to make strategic decisions and commit resources on, to act in a leadership role as a safeguarding champion, to have the authority to hold their own agency to account for its safeguarding performance, and to understand safeguarding issues.

Board membership was seen as creating a number of obligations at both agency and individual level. These were commonly set out in detail in Board documentation, and with some formality, requiring members for example explicitly to sign their acceptance of the terms and conditions. For agencies, membership required them to:

- Ensure the agency had rigorous procedures for a range of matters, including recruitment and selection of staff, risk assessment, recording, reporting and reviewing incidents of harm, responding to allegations against members of staff, whistleblowing;
- Provide staff with clear operational guidance and appropriate training in areas of potential safeguarding risk;
- Implement “No Secrets” and the multi agency procedures;
- Monitor the quantity and quality of safeguarding work within their agency and provide monitoring information to the safeguarding coordinator and an annual report;
- Designate a lead officer;
- Contribute to the strategic direction of the Board.

Individual members were also required to honour commitments that would enable their agencies to fulfil these expectations, for example: acting as a communication link between the Board and their agency; securing resources to support the work of the Board; alerting the Board to any issues of safeguarding strategy or operations that arise in their agency; monitoring their agency’s compliance with procedures and quality review initiatives; acting as a safeguarding voice in all their other work (for example with other committees). Nolan principles^v were sometimes used as benchmarks for the conduct of Board members.

The safeguarding manager or operational coordinator in the local authority often played a key advisory, coordination and/or operational role in relation to the Board. In some cases this person was accountable to the Board. The literature pointed to the importance of thinking through this individual’s role and accountability in order to avoid the post becoming the sole location of safeguarding work, thereby deskilling teams (Cambridge and Parkes, 2006a). One resolution was for the post holder to

deal with complex institutional abuse cases and provide consultation on other adult protection work (Larkin and Fox, 2009).

One key issue relating to Board membership was the question of chairing, with the role of independent chairs much debated in the workshops. The number of independent chairs was growing but many Boards were still chaired from within their membership (usually by the Director of Adult Social Services or other senior officer). Some were exploring the appointment of an independent chair, and the experiences of those with independent chairs were largely very positive. Three regions had undertaken work on independent chairing - a measure of the level of interest in what it has to offer Boards - but no formal evaluations of the outcomes of different chairing arrangements were uncovered.

Independent chairing of the Board was perceived to offer several advantages, notably transparency, challenge and scrutiny (see also Manthorpe, 2005; Harbottle, 2007), with capacity to bring a greater degree of challenge to the collective safeguarding system, to identify and allocate responsibilities without agency self-interest, to demonstrate fairness in holding agencies to account, to mediate in interagency power relations, and to bring external credibility in the public perception.

There were also some perceived disadvantages. These included a potential distancing of the local authority from its lead role and reduction of involvement from senior local authority personnel, a possible abdication of responsibility from other statutory partners, a lack of authority in the chair to resolve difficult interagency political issues, compounded by lack of insider knowledge making it difficult to intervene in local politics and agendas, and additional financial costs.

If these disadvantages did occur in practice, there was little evidence that they were irresolvable or adversely affected the Board's functioning. The exception to this was the undoubted cost of payments to those in independent chair positions, although by no means all independent chairs were paid.

The role of the chair was rarely specified, but was more likely to be so in respect of independent chairs. Boards here had developed their thinking on expectations and attributes, and produced job descriptions and person specifications to assist open recruitment. The role was envisaged as leading the Board on the development of its mission, overseeing its performance and ensuring proper conduct of business. It also included the promotion of inter-agency working, development of external relationships, presentation of the Board's work to the public, and representation in regional and national arenas. The accountability of the chair too was more likely to be specified in the case of independent chairs, who most commonly reported to the Director of Adult Social Services, although reporting to the Chief Executive of the Council or to the Executive Board of the safeguarding partnership, was also apparent. Some independent chairs, however, reported a lack of clarity over their own accountability.

Boards generally had detailed rules of engagement designed to ensure that their business was conducted in a robustly regulated manner. These include specification of meeting frequency, quoracy and protocols, and financial regulation.

In relation to finance, the literature reported some pooling of resources but was also critical of the absence of levers to secure funds, commenting that lack of resources affects working together (Perkins et al., 2007; Pinkney et al., 2008; Larkin and Fox, 2009; Reid et al., 2009). In practice, funding for Boards had in many areas proved problematic and securing resources for the work of the Board remained a key challenge. The position of Safeguarding Adults Boards was compared unfavourably with Local Safeguarding Children Boards where resource commitments were much clearer^{vi}. Boards rarely had their own dedicated budgets. Where they did, costs were often shared between the lead statutory partners – social care, health and police. The default position, in the absence of cost sharing, was that the local authority funded the work of the Board; partner agencies were sometimes reluctant to commit financial resources, but contributions to costs were frequently made in kind. The lack of a national performance indicator on adult safeguarding was identified as a barrier to securing resources through the local strategic partnership, but Boards were increasingly using business planning models to make the case for robust support.

Service user and carer membership of Boards was not routinely established (mentioned in the documentation of only 25% of boards surveyed), and was the subject of some debate. Those in favour advocated very strongly on principle that participation in Boards was the right way forward. Some very proactive work was being done to build capacity for such participation and to secure advocacy and support for service users (Hampshire Safeguarding Adults Service User Forum, undated). Other participants questioned the purpose of participation in Board discussions and considered that more effective engagement with service users' perspectives could be achieved through other mechanisms. Participation was more established at sub-group level, with a number of examples found of groups and forums designed to include service users in the Board's business. No examples of specific protocols for participation were found, and where membership was offered it was not always clear how representation was determined, and whether places were taken by service users and carers themselves or by the staff of organisations working on their behalf. These findings were echoed in the literature, which suggests that Safeguarding Adults Boards have struggled with how to engage service users and carers (CSCI, 2008; Perkins et al, 2007; Reid et al., 2009) although some documented examples do exist (PAVA, 2004; McKeough et al., 2009).

Board functions

The literature contains little detail of what Boards actually do, although papers have described approaches to quality assurance and audit (Manthorpe, 2005; Giordano and Street, 2009), the role of an adult protection coordinator in inquiries (Cambridge and Parkes, 2006), and the dissemination of protocols, policies and inter-agency agreements (Sumner, 2004). The importance of serious case reviews and inquiries

has been discussed (Manthorpe, 2003; Cambridge, 2001; McKeough, 2009), noting that the absence of a statutory duty to cooperate makes it difficult to secure agency buy-in and to negotiate challenges surrounding confidentiality and data protection (Brown, 2009).

From the workshops and review of documentation, seven broad functions emerged (see Figure Six), capturing Board functions that have key strategic importance.

FIGURE SIX ABOUT HERE

First, the strategic planning function reflected Boards' core engagement with leadership for adult safeguarding. Some Boards adopted a clear rational planning model in which strategic goals gave rise to operationalised priorities, and clear action steps for which responsibility was allocated.

Second, producing policies, procedures, protocols and guidance was a key way in which Boards attempted to secure adherence to consistent standards across agencies. Guidance commonly covered the following aspects of safeguarding:

- Multi-agency cooperation, including information-sharing, data protection, confidentiality, cross border protocols;
- Underpinning values;
- Safeguarding investigation procedures;
- Preventive strategies;
- Legal frameworks;
- Capacity and consent;
- Interface with risk areas such as honour violence, hoarding, domestic abuse, forced marriage;
- Interagency conflict resolution;
- Case review;
- Workforce development;
- Complaints and whistleblowing;
- Liaison with specific sectors such as financial institutions.

Third, Boards had evolved mechanisms for quality assurance of member agency practice. These included monitoring of statistics, audit and inspection, management and serious case reviews, commissioning and contracting, evaluation of training, external peer review and quality improvement action plans.

Serious case reviews, although not mandated by statutory regulation, were increasingly used as a means of reviewing interagency practice. They constituted a key quality improvement tool when the findings were disseminated and led to targeted action for improvements to practice. Boards commonly issued detailed and extensive guidance on the conduct of reviews, often adopting the ADSS (2005b) protocol. Their effectiveness, however, could be compromised by lack of interagency engagement in the review process in the absence of a duty to cooperate. Management reviews within agencies were also thought to require strengthening

and the interface with NHS clinical governance procedures was not well established. The findings of serious case reviews are not collated at national level, and thus broader impact is limited.

Fourth, some Boards saw promoting participation by service users and carers as one of their functions. There were some proactive and well-established practices, but these were by no means consistent. In addition to moves to include service users and carers in Board or sub-group structures, developments focused either upon ways of empowering service users to participate in their own safeguarding (by setting standards for staff, or providing access to advocacy) or upon post hoc feedback on their experience (through debriefing and review of satisfaction, or sometimes more structured research).

One very proactive service user forum had undertaken major projects to empower service users through developing user-defined standards and outcomes for adult safeguarding, devising a charter for service users, and promoting an audit tool for use by the Board and by partner agencies to benchmark their practice. The forum had also developed and tested out ways of staying safe and offered training to service users to deliver 'staying safe' training to others. The Board had developed a contract to express how it would account to the forum for its work.

Facilitators of empowering levels of participation included Board members' commitment, support and leadership from senior staff, openness and honesty of communication, commitment to a rights-based approach, and investment of time and funding. That this remains a challenging area was reinforced by concerns in the literature relating to people's lack of involvement in decision-making regarding their own protection, low expectations and reluctance to speak out, and exclusion from policy development (Wishart, 2003; Penhale et al., 2007; Filinson, 2008; Giordano and Street, 2009).

Fifth, Boards engaged in awareness raising and publicity, although the literature points to patchy dissemination of public information (Sumner, 2004; CSCI, 2008; Pinkney et al., 2008). Information had two main targets - education of the general public about safeguarding and education of groups thought to be particularly at risk, in order to enhance self-protective capacity.

Sixth, engagement with training and workforce development was a widespread and long-established Board function, with descriptions also found in the literature (Giordano and Badmington, 2007; McKeough, 2009). There had been little attention, however, to the outcomes of training, thus making it difficult to assess the impact on practice and for service users. Published literature has reported the same concern (Manthorpe, 2005), alongside doubts about adequacy in terms of frequency and level (Harbottle, 2007; Pinkney et al., 2008).

Finally, Boards had a clear change-management role in creating the necessary interagency relationship infrastructure in which safeguarding practice can thrive. Building, nurturing and trouble-shooting interagency relations were key functions,

alongside the role of calibrating the Board's activities with those of other local partnerships.

Boards recognised the need to monitor their own performance in their functional roles, and were doing so through various mechanisms. ADSS standards (2005a) had been influential in setting out expectations, and the work of Joint Improvement Partnerships provided a framework for evaluating the strength of 'working together' practices, essentially focusing on leadership, quality assurance, strategic alliances, participation and accountabilities. Peer review was developing as a valued means of benchmarking also, drawing on frameworks developed by IdEA (Humphries, 2010).

Published research also provides some indicators of quality (Sumner, 2004; Manthorpe, 2005; Perkins et al., 2007; Reid et al., 2009), focusing on: clarity of roles and responsibilities; partnership activity and working across boundaries; strength of policy and communication systems; adherence to national standards and legal requirements; performance monitoring and improvement action planning; contract monitoring; robustness of training, information-sharing and recording; level of reporting of abuse and neglect; outcomes for service users.

Accountability

Two dimensions of accountability emerged in this research. First was the Board's *accountability to* the external bodies to whom it owed an account of its work; second was the notion of *accountability for* the work of its member agencies. In relation to *accountability to*, there were two main routes:

- Accountability to the Council, expressed through the overview and scrutiny committee, or to the cabinet;
- Accountability to the Local Strategic Partnership, expressed through its Health & Wellbeing Partnership, or the Crime & Disorder Reduction Partnership.

Some Boards reported to both, some to one, and some to neither of these; other reporting routes included to the Council executive through the Director of Adult Social Services, to service users and carers, to partnerships such as MARAC and MAPPA, to the mayor, to the NHS PCT Board, to NHS Trust Boards and to the managing boards/trustees of partner agencies. The annual report was often a means of giving an account of the Board's work and thus served some of the functions of accountability arrangements.

But this diversity and complexity of reporting routes masked a core lack of clarity about different accountability functions that were being met by reporting through the various channels. Accountability – liability to give an account to others for one's actions and decisions – is core to governance. However, in a world of partnerships and strategic alliances, formal hierarchical lines of accountability are more difficult to discern. The notion of an accountability matrix is probably more helpful than any hierarchical model in understanding the safeguarding accountability framework. Hierarchical models of accountability imply that at some level there is external

authority from which the Board draws its mandate to act, and to which it must therefore answer. This was not quite the case. It is rather a question of the Board engaging in diverse forms of accountability, using a more nuanced set of definitions (Leat 1996):

- Explanatory accountability (owed to those to whom one's actions must be justifiable);
- Accountability with sanctions (to those who have the power to overrule);
- Responsive accountability (to those who should be consulted but not necessarily obeyed).

Some forms of accountability serve the function of scrutiny; others serve the function of engaging with stakeholder needs and priorities. Board documentation did not distinguish between these, but participants expressed concern about the challenges of multiple partnership engagement. The question of who takes responsibility for what was a challenge; if everyone has a hand in everything, and the boundaries are not clear, there is a danger that some things don't get picked up by anyone. This potential was seen as exacerbated by a lack of statutory duties. Additional complicating factors were:

- the parallel systems for clinical governance arrangements;
- conflicts of interest that arise when a Board member is also part of the scrutiny and accountability arrangements for the Board, as, for example, with the Director of Adult Social Care, and elected members if they also sit on the Board.

A further important aspect of *accountability* was that owed to the least powerful stakeholders – people at risk and their carers. A key mechanism for empowerment is strengthening the accountability arrangements between the Board and those whose wellbeing it works to protect.

The second form of accountability was the Board's *accountability for* the work of its members. This was addressed partly by specifying the responsibilities of membership (see above). However, one key unresolved issue remained the nature of the authority the Board holds in relation to its members. The range and scope of Boards' powers over decisions were not commonly spelled out, although where they were, it was usually to specify that they were in fact quite limited; member agencies commonly retained the right to consider (and ratify or otherwise) their adherence to the Board's decisions. The Board's authority was in effect a consensual authority, exercised over its members through their agreement to grant it executive powers and be bound by them. Memoranda of Understanding created between Board members thus had an important function in codifying the permissions that member agencies accorded each other.

Concluding discussion

The research reported here set out to uncover best practice in the governance of adult safeguarding, with particular reference to the role and function of

Safeguarding Adults Boards. Only half of Safeguarding Adults Boards have been judged to be working effectively (CSCI, 2008). An important question therefore, if best practice is to be defined, is the extent to which governance mechanisms impact upon safeguarding performance. There is however no evidence in the literature that particular forms of governance lead directly to improvements in safeguarding, and whilst participants in workshops and interviews had their own perspective on ‘what worked’, these were formed purely through personal experience and observation. To help fill this gap, the present study scrutinised 13 CQC adult social care inspection reports from 2008 and 2009; these provided some evidence to suggest that particular governance arrangements may be associated with strong performance at least as assessed by CQC inspection. Characteristics identifiable as present in authorities receiving high inspection scores and positive review on their safeguarding work included strategic leadership from the board with strong engagement from senior managers, cabinet and committees, independent chairing, strong partnership protocols, dedicated resources, clear safeguarding procedures and consistent implementation. Also important were strong management oversight, knowledgeable staff who understood capacity and choice, service user and carer involvement, robust quality assurance, strategic approaches to training, strong information strategies, informative annual reports, and clarity of accountability arrangements.

Other fields have developed principles of good governance that can also benchmark the arrangements in adult safeguarding. A universal standard for governance (OPM & CIPFA 2004) prioritises 6 core principles – clarity of purpose and outcomes, informed and transparent decision-making coupled with risk management, development of Board capacity and capability, stakeholder engagement and meaningful accountability, effective performance against clearly defined roles and functions, and promoting values and demonstrating good governance through behaviour. The Audit Commission (2005) has addressed the additional challenge of securing accountabilities between partners in a network. It has also developed standards by which to track performance, such as that offered in the 7S Framework (Audit Commission 2009) that scrutinises standards, systems, synergies, style, staff and skills, steering and sustainability (strategy). Principles of good governance have also emerged in children’s safeguarding (NSDU 2009; France et al., 2010).

Drawing on these frameworks alongside all the evidence reviewed in the present study, Boards with strong and robust governance arrangements will have paid detailed attention to the key features of goals and purpose, structure, membership, functions and accountability. An emerging framework of benchmarks can be outlined.

| Strategic goals and purpose |
|---|
| <ul style="list-style-type: none"> • Strong statements of principle expressing core commitments to safeguarding, its underpinning values and the values that inform the means of achieving good safeguarding outcomes; • Explicit commitment to the multiagency nature of responsibility for and ownership of safeguarding; |

- Clarity of strategic goals identifying top level outcomes sought by the board;
- Good environmental scanning demonstrating sound awareness of the policy environment, awareness of new challenges and risks, and proactive innovation in addressing these;
- Definition of scope including attention to different types of safeguarding activity, from preventive to reactive, from community to individual focus, and to the breadth of perceived solutions, including attention social and environmental factors.

Structures

- Clear divisions of responsibility between board, executive, operational group and sub-groups, all having clear goals and terms of reference (horizontal differentiation);
- Mechanisms to ensure vertical communication/coordination through the layers of the structure (vertical coordination);
- Structures (whether sub-groups or ad hoc working groups) that enable detailed work in specific areas to be progressed (vertical differentiation);
- Explicit linking between the sub-groups, ensuring that the work of each is taken account of in the work of the others (horizontal coordination).

Membership

- Evidence that agencies have entered into explicit commitments to the explicit requirements associated with membership of the partnership;
- Clear identification of the roles of different agencies and their contribution to safeguarding;
- Clear membership strategy and rationale for inclusion;
- Appropriate means of engaging with stakeholders not represented on the board;
- Clarity on service user and carer involvement that permeates the board and its structures;
- Clear descriptor for the role of the chair, containing clear identification of functions, reporting and accountability mechanisms;
- Detailed specification/regulation for the internal procedures of the board, quoracy, meeting protocols, etc.
- Identifiable resources accessed by the board to pursue its functions, and clarity on contribution from partner agencies.

Board Functions

- Clear strategic plan, identifying objectives and actions;
- Clear differentiation between strategic and operational documentation;
- Clear commentary on annual statistical monitoring, what it implies and how it informs strategy;
- Clear and accessible guidance on safeguarding procedures, avoiding undue proliferation and overlap;
- Clear and up-to-date guidance on related areas of professional knowledge, e.g. legal guidance for staff on capacity, best interests decisions, DoLS, whistle-blowing, confidentiality, managing finances along with encouragement to speak

| |
|---|
| <p>out and support to do so;</p> <ul style="list-style-type: none"> • Detailed policy setting out decision-making on SCRs, including criteria, commissioning, reporting, panel governance, implementation of recommendations and reviewing impact; • Training and workforce development strategy; • Protocols for cross agency engagement on issues pertinent to collaboration (e.g. information sharing); • Clear articulation of QA strategy and mechanisms, emphasising a proactive central steer from the board on accountability of members to the board, benchmarking, monitoring and performance management including case file audit and practice surveys involving practitioners and service users, all with strong channels for feeding QA outcomes into practice improvement; • Benchmarking against local comparator group, the national picture, research and findings of enquiries elsewhere; • Evidence of quality improvement initiatives, detailing implementation of recommendations from previous inspections; • Clear, accessible and informative annual reporting on all the Board's functions. |
| <p>Accountabilities</p> <ul style="list-style-type: none"> • Clear standards for the board, and a strategy for achieving/maintaining those standards; • Clear performance targets for the board, related to its various functions, and mechanisms for tracking/evaluating its performance; • Clarity about the authority and decision making capacity of the board; • Clear complaints procedures; • Clarity on accountabilities/reporting lines, including links with other safeguarding partnerships (children's, health). |

Specific legislation for Safeguarding Adults Boards that delineates roles and functions, membership and accountabilities might help to standardise policy and procedures, to hold agencies more easily accountable, to clarify responsibilities, and to ensure participation in ways which statutory guidance, differentially binding on the partners, has not so far been able to do (Penhale et al., 2007). Perhaps this explains why workshop participants were exercised by the question of the Board's authority; by some this was seen as the central question, but one that was not easy to answer. The perceived looseness of the Board's mandates and the complexity of its networks left much to local discretion but there was a sense of frustration that safeguarding was not securely tied into strategic local planning priorities other than by the tireless efforts of its champions, and was therefore vulnerable. However, although calls for legislation abound (Perkins et al., 2007; Brown, 2009; Draper et al., 2009; Larkin and Fox, 2009; McKeough, 2009), good governance will also require ongoing individual and organisational commitment to strategic and operational partnership, information-sharing, resource availability, inter-agency engagement with and championing of adult safeguarding, and focused, sustained action.

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ⁱ The views expressed in this article are the authors' own and should not be taken as reflecting government policy.

ⁱⁱ This figure also includes references obtained from a linked search for material on self-neglect and adult safeguarding, for a parallel piece of research again commissioned by the Department of Health and subsequently published (Braye et al, 2011b).

ⁱⁱⁱ The date of 2000 was selected to match the publication date of adult safeguarding guidance No Secrets (DH, 2000).

^{iv} Research Ethics Committee reference number 09/IEC08/19

^v “The Seven Principles of Public Life” set out in the First Report of Lord Nolan’s Committee on Standards in Public Life.

^{vi} Section 15, Children Act 2004, details the agencies that may contribute to the funding of work relating to safeguarding children.

Figure one: the scope of adult safeguarding

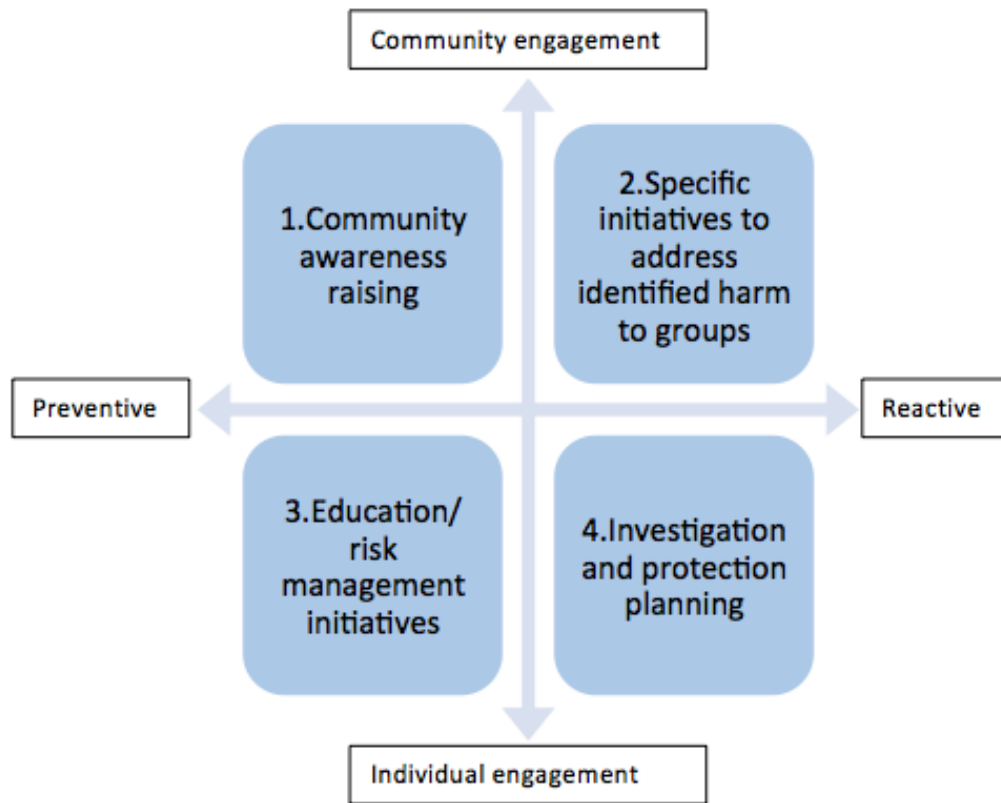


Figure two: principles that underpin Boards' goals and purpose



Figure three: vertical and horizontal coordination

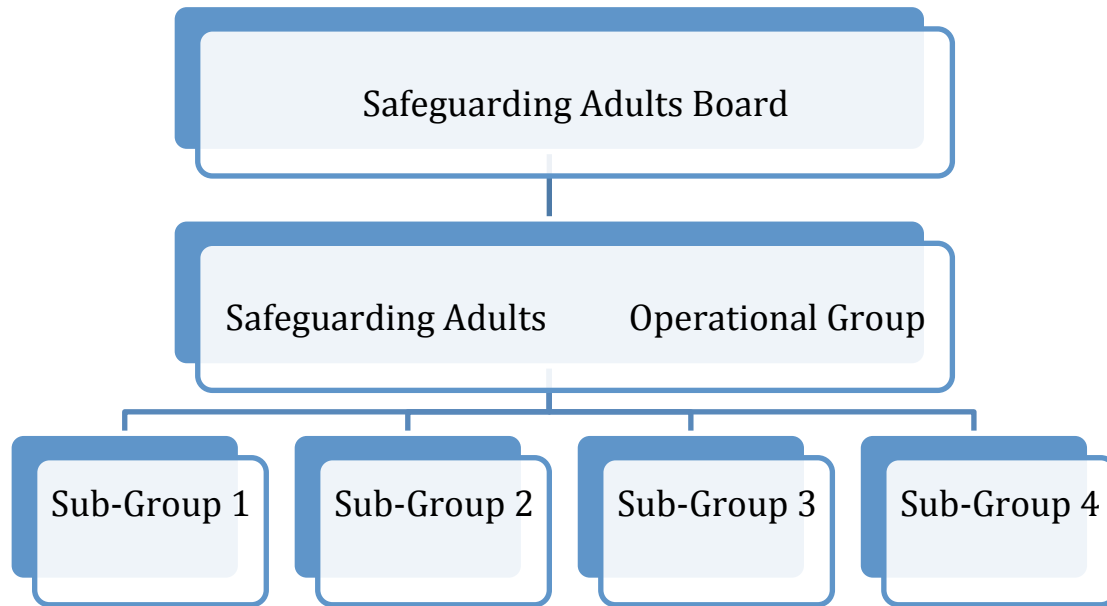


Figure four: boards' links with other bodies

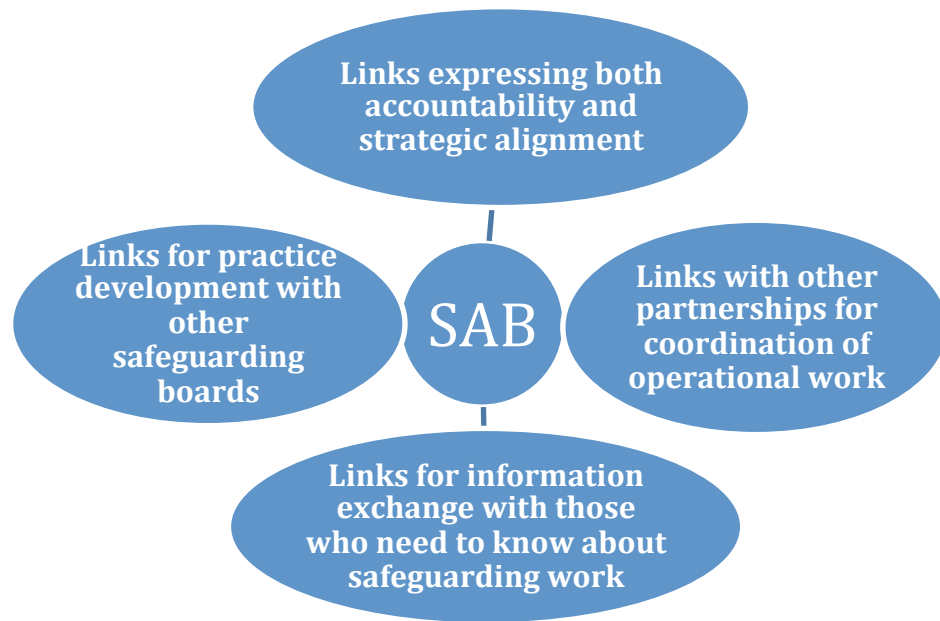


Figure five: patterns of board membership

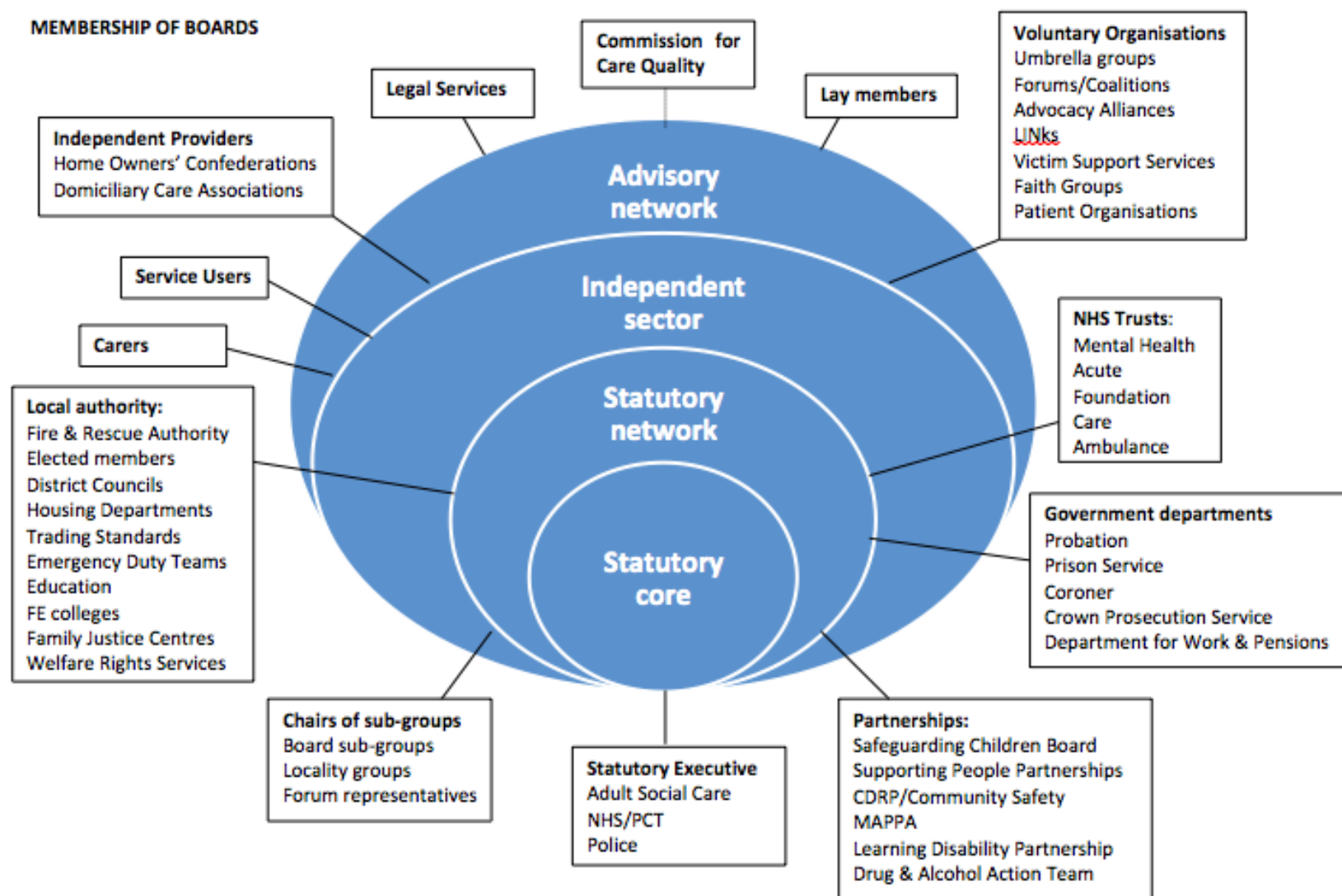


Figure six: board functions

